

471-000-222 Instructions for Completing Form DM-5-LTC, "Long Term Care Evaluation" for the Preadmission Screening Process (PASP)

Use: Form DM-5-LTC is used to

1. Secure information necessary to establish nursing facility level of care for individuals who are requesting admission to the NF and require a Level II evaluation for a positive screen;
2. Establish level of care within 15 days for admission to swing bed; and
3. Pre-screen certain cases for long term care services.

Number Prepared: One copy of Form DM-5-LTC is completed.

Completion: The facility completes Form DM-5-LTC by entering all information (nursing, social, emotional, etc.) relevant to the present status of the individual.

Signature: The staff person of the facility signs and dates Form DM-5-LTC.

Distribution: For a positive screen/Level II evaluation, the facility holds Form DM-5-LTC for the HHS Contractor. For swing bed authorization, the facility sends Form DM-5-LTC with the MC-9-NF, the history and physical, and medication/treatment list to the Central Office.

Retention: Form DM-5-LTC is retained for four years for PASARR.

Form DM-5-LTC Long Term Care Evaluation		<input type="checkbox"/> Initial Review (Physician Certification Attached)		<input type="checkbox"/> Other (Specify) _____	
• Use Medium Ball Point Pen or Typewriter • Press Hard - you are making four copies		<input type="checkbox"/> Change of Classification (Physician Certification Attached)			
Local Office of Finance	Date Completed				
Eligibility Date	Date of Admission	Period Covered: _____ From To			
Resident's Name		Social Security Number		Date of Birth	
Facility Name	Street Address	City	State	Zip Code	
Diagnosis: Primary (Related to present medical condition)		Secondary			
Physician	Date Last Seen	Classification <input type="checkbox"/> Skilled <input type="checkbox"/> ICF			
Caseworker	Medication (Include dosage, route of administration, frequency, times)				
Treatments (Include oxygen, therapies, and frequency, etc.)		PRN Medications (Include frequency that administration is needed)			
Check Where applicable		<input type="checkbox"/> Skin Breakdown or Decubiti (Describe) _____			
<input type="checkbox"/> Complete Bedrest		<input type="checkbox"/> Restraints		<input type="checkbox"/> Special Dressings	
<input type="checkbox"/> Must Be Lifted		<input type="checkbox"/> Feeds Self		<input type="checkbox"/> Is Alert and Well Oriented	
<input type="checkbox"/> Chairfast		<input type="checkbox"/> Must Be Fed		<input type="checkbox"/> Understands Simple Directions	
<input type="checkbox"/> Self-Mobile in Wheelchair		<input type="checkbox"/> Indwelling Catheter		<input type="checkbox"/> Untidy/Messy Personal Habits	
<input type="checkbox"/> Walks With (Be specific)		<input type="checkbox"/> Ileostomy-Colostomy		<input type="checkbox"/> Combative/Belligerent	
<input type="checkbox"/> Walks Alone		<input type="checkbox"/> Incontinent, Bladder		<input type="checkbox"/> Confused/Disoriented	
<input type="checkbox"/> Naso-Gastric Tube		<input type="checkbox"/> Incontinent, Bowel		<input type="checkbox"/> Withdrawn/Depressed	
<input type="checkbox"/> Suctioning		<input type="checkbox"/> Bed Bath			
<input type="checkbox"/> Contractures (location)		<input type="checkbox"/> Assistance with Bath			
Caseworker Comments Regarding Visit with Client		Current Goals for Resident			
Social Service and Activity Involvement (Please list)		Comments (as to need for level of care including previous living arrangements)			
This form completed by:					
Sign Here		Nursing Home Personnel Signature		Title	
Sign Here		Caseworker - Local Office of Residence		Title	
DO NOT WRITE IN THIS AREA					
Reviewer's Name and Action					

WHITE - State; YELLOW - Local Office; PINK - Facility; GOLDENROD - Medical